TESTIMONY BEFORE THE

HEALTH SUBCOMMITTEE

OF THE

HOUSE ENERGY AND COMMERCE COMMITTEE

ON

LONG-TERM CARE FINANCING

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Mr. Chairman and members of the Subcommittee, I am Jennie Chin Hansen, a member of AARP's Board of Directors. Thank you for the opportunity to testify today.

Affordable long-term care is a critical issue for AARP members and their families. I learned this firsthand as the Executive Director of On Lok, Inc., a non-profit family of organizations that provide comprehensive primary, acute, and long-term care services to nearly 950 frail older persons and 5,000 other older adults in San Francisco.

AARP believes the time has come to reinvigorate a national debate over how to help Americans plan for and obtain the long-term care services they need in the most appropriate setting. To that end we commend the Subcommittee for holding this hearing. We hope that this is the first in a series of ongoing discussions.

The Need for an Affordable System of Long-Term Care

Americans are living longer than ever thanks to tremendous advances in medicine and public health, and this longevity brings the need for appropriate long-term care. The segment of our population age 85 and older – those most likely to need long-term care – is estimated to increase by over 2.6 million people (about 60 percent) between 2002 and 2020. Baby boomers are now nearing

retirement, taking care of aging parents, and facing their own future long-term care needs. In the near future, more Americans in their 60s will be caring for people in their 80s and 90s. We hear from our members every day who are trying to do the right thing -- balancing the demands of work and family and balancing their personal finances, while worrying about their future retirement income and how to pay for long-term care.

Unfortunately, aside from a handful of programs like On Lok, there is no comprehensive public system of long-term care available to most Americans and very few other long-term care financing options exist. Long-term care insurance is limited and generally expensive. According to America's Health Insurance Plans, in 2002, the average cost of a long-term care insurance policy with automatic inflation protection was $1,134 per year when purchased at age 50 and $2,346 per year if purchased at age 65.

Public programs are also limited. Medicare provides some home health and skilled care, but does not cover nursing home stays. Medicaid's income and asset limits require impoverishment. For those people who pay out-of-pocket for their care, the expense associated with years of care often outstrips personal savings. According to a recent MetLife Marketing Institute report in 2004, the average annual nursing home costs were over $61,000 for a semi-private room and over $70,000 for a private room. The average hourly rate for a home health

aide in 2004 was $18, so as little as 10 hours a week of home health care would average over $9,000 per year.

Many Americans currently rely on informal caregivers for the bulk of long-term care services. According to a forthcoming analysis of data from the National Long-Term Care Survey for AARP, over 90 percent of persons age 65 and older with disabilities who receive help with daily activities are helped by unpaid informal caregivers. Two-thirds of those 65 years of age and older with disabilities who receive help with daily activities only receive informal unpaid help. But caregivers face many physical, emotional, and financial demands that often take a serious toll.

One of the fundamental issues at the heart of the current Medicaid debate is how to provide Americans and their families with alternative options for financing long-term care services while maintaining Medicaid as a critical safety net program for the millions of lower income Americans who rely on it for health care. The notion that middle and upper income Americans are clamoring to qualify for long-term care coverage through a poverty program is far from accurate. The problem is that there are few other options available.

We believe one way to change the paradigm is to create new choices that give consumers more control and allow older Americans and people with disabilities to age with dignity and independence in the setting of their choice. We also

believe it is important that consideration of specific long-term care financing options be made in the context of this broader discussion, and not be driven by the current budget debate and a specific budget target.

As Congress begins to explore new financing options, we should look to the growing role that private financing is already playing to support people with disabilities and their families with the home-and community-based services that they prefer. Our members want greater control over the services they receive and the providers of those services. Policymakers, providers, and consumers should work together to bring about comprehensive changes in the way we finance and deliver care. At the same time, we must work to strengthen Medicaid to ensure that it provides choices and quality care to the persons who rely on the program.

Our testimony today focuses on three specific financing options for long-term care and the pros and cons of each: reverse mortgages, long-term care insurance, and the Long-Term Care Partnership Program.

Reverse Mortgages

Because of the large and growing amount of home equity held by some older Americans, increased attention is being paid to the role this resource could play in financing long term care. Over the past decade, more homeowners have

begun using their home equity as a means of paying for long-term care services. In some cases, they have done so by selling their homes and reassigning the proceeds to assisted living and continuing care retirement communities (CCRCs). Others have used home equity to retrofit their houses or to pay directly for home and community-based services. Still others have chosen reverse mortgages for purposes other than long-term care.

There are two basic types of reverse mortgages: public sector reverse mortgages that must be used for a single purpose and private sector reverse mortgages that can be used for any purpose. Public programs are offered by some state and local governments, generally at a low cost, and with income requirements. Most of these programs are limited to paying for home repairs or property taxes, although Connecticut developed a program specifically for long-term care financing.

Private sector reverse mortgages include the Home Equity Conversion Mortgage Program (HECM) that is insured by the Department of Housing and Urban Development (HUD), as well as two smaller private programs. HECMs make up more than 90 percent of the private sector reverse mortgage market.

To qualify for a reverse mortgage, an individual must: be age 62 or over; occupy the home as a primary residence; have paid off the mortgage or have a mortgage balance that could be paid off with proceeds from the reverse mortgage at

closing; undergo required counseling in the HECM program; and live in a home that meets minimum HUD property standards. According to a recent study, HECM borrowers tend to be older, female, racially and ethnically mixed, live alone, and have lower incomes.

The chief advantages of these loans are that there are no income limits or requirements, and there are no required monthly repayments. The amount of money available depends upon the: age of the youngest borrower; the value of the home; the median home value in the county; current interest rates and other loan costs; and the type of private sector loan. Money from the reverse mortgage can be paid to the borrower as a lump sum payment at closing, monthly payments, a line of credit, or a combination of these methods. Borrowers make no loan payments as long as they live in the house. The loans are paid back when the last living borrower dies, sells the house, or permanently moves away.

A considerable downside to reverse mortgages is the high costs associated with the loans. For example, the total upfront costs and deductions on a HECM loan for a typical borrower (75 years old and living in a home valued at $230,000) is about $16,500. This amount is nearly equal to the $17,000 median income of HECM borrowers.

Another disadvantage is the small size of the private reverse mortgage market. Even though HUD indicates the market is growing, only about 139,000 HECM loans have been taken out since the program's inception in 1989. High costs are a key reason cited by prospective borrowers for deciding against a HECM.

Reverse Mortgages are Not Always the Answer

In 2000, Congress included a provision in the American Homeownership and Economic Opportunity Act that waives the upfront mortgage insurance premium for individuals who get a reverse mortgage through HECM if all the available equity is used to buy long-term care insurance. Consumer organizations – including AARP – have objected to the required tie to an insurance purchase and, to date, HUD has not implemented the program.

Tying the purchase of long-term care insurance to a reverse mortgage is expensive for the consumer and not necessarily the best way to finance needed services. The homeowner pays all the costs associated with the reverse mortgage plus the premiums and cost-sharing for the long-term care insurance policy, and it is not required that consumers be informed of the total, combined cost. Over time, reverse mortgage costs can double or triple the total cost of purchasing long-term care insurance due to high upfront loan costs and the growing amount of interest charged on the loan. Homeowners who can afford long-term care insurance without borrowing would be unlikely to need to use a

reverse mortgage for this purpose particularly if they know how much the loan would add to the total cost. If homeowners cannot afford to buy long-term care insurance, it would not be wise to use a reverse mortgage to purchase the insurance since the reverse mortgage only adds to the cost of the insurance.

Another issue is the lack of a requirement to disclose the risks related to long-term care insurance policy cancellation or lapses, HECM loan default, or Medicaid eligibility. For example, if an individual exhausts all available reverse mortgage funds for the long-term care insurance premiums and is no longer able to pay the premiums, the policy could be cancelled or lapse due to nonpayment. The insurance coverage would be lost; the borrower would owe substantial and growing debt on the home, and would no longer be able to pay for the cost of long-term care.

Finally, borrowers could only use the loan money for insurance policies and not to directly purchase home-and community-based services or for home modification that may better meet their needs. Most older Americans want to remain in their homes and are looking for ways to get needed services there rather than be institutionalized. Use of reverse mortgages may be one means of financing long-term care, but consumers should not be required to use their equity to purchase an insurance policy. Rather, they should have the choice to use the equity for the appropriate services in the setting of their choice.

In addition, some are considering requiring the use of a reverse mortgage in order to qualify for Medicaid. AARP does not support such a proposal. A reverse mortgage requires that a significant portion of home equity is used to pay for the costs of the reverse mortgage, rather than paying directly for long-term care needs. In fact, according to a recent study by Mark Merlis, there could be cases under such a proposal in which Medicaid actually ends up spending more to care for someone with a reverse mortgage. This is because Medicaid can recoup more of the money it spends through estate recovery if none of the home's equity has already been consumed by the high upfront costs and growing interest charges on a reverse mortgage. With a prior reverse mortgage, Medicaid cannot recover home equity that has already been used to pay the high costs of the loan.

Requiring a reverse mortgage before Medicaid eligibility would be particularly burdensome for persons owning lower-valued homes. For example, a 62-year-old living in a $50,000 home could qualify for a HECM reverse mortgage of just under $29,000 - but over $10,000 of that amount would be needed for upfront loan costs and deductions, leaving the borrower with less that $19,000 in available loan funds. Medicaid would be requiring this homeowner to obligate over $10,000 of home equity in order to borrow less than $19,000.

This proposal raises many other concerns including the fact that taking out a reverse mortgage to cover the nursing home costs of a spouse would expose a surviving community spouse to much greater risk of impoverishment.

Opportunities to Test the Use of Reverse Mortgages

Given the limited experience most consumers have with reverse mortgages, a logical way to test this approach is through a limited demonstration program. One approach is to look at two ways to reduce borrower costs: 1) with modest, one-time public subsidies and competition among private providers in the HECM program, or 2) by building on the experience of low-cost public sector reverse mortgage programs to develop public loans for long-term care. Either way, borrowers would be able to access their own home equity to pay for the lower-cost services they want instead of waiting for estate recovery and liens to reimburse Medicaid for the institutional care they want to avoid.

Demonstration programs would allow for the examination of how people could use reverse mortgages to pay for their long-term care needs, which segments of the population might best be served by using reverse mortgages, how reverse mortgages could help expand access to home-and community-based services, and how to give people more choice and control in how they receive long-term care services.

The public sector has experimented with reverse mortgages relating to long-term care. The HECM program also provides valuable experience that could be drawn on to establish a demonstration program to allow older homeowners with disabilities to remain in their homes longer by using reverse mortgages to pay for services that they need to remain independent. Reverse mortgages could pay for things like home health care, chore services, and home modification.

Demonstrations would create opportunities for the federal and state governments, the private sector, and consumer groups to work together to explore the potential of reverse mortgages to pay for long-term care. There is time to carry out demonstration programs to test new approaches, to bring down the cost of reverse mortgages, and to make sure we get the policy right.

Long-Term Care Insurance

Relatively few older persons have private insurance that covers the cost of long-term care. Many common long-term care needs (e.g. bathing, dressing, and household chores) are not medical in nature, do not require highly skilled help and, therefore, are not generally covered by private health insurance policies or Medicare. Long-term care costs are significant. The average hourly rate for a home health aide in 2004 was $18, so even just ten hours of home health care per week would cost over $9,000 per year. Average annual nursing home costs

were over $61,000 for a semi-private room and over $70,000 for a private room in 2004, according to a recent MetLife Mature Marketing Institute report.

The market for private long-term care insurance has grown in recent years, but its overall role is still limited. Currently long-term care insurance pays for only about 11 percent of all long-term care costs. By the end of 2002, over 9.1 million long-term care insurance policies had been sold in the United States with about 6.4 million of these policies still remaining in force. Most policies sold today cover services in nursing homes, assisted living facilities, and in the home. Typically, policies reimburse the insured for long-term care expenses up to a fixed amount, such as $100 or $150 per day. To receive benefits, the insured must meet the policy's disability criteria. Nearly all policies define disability as either severe cognitive impairment or the need for help in performing at least two activities of daily living (such as bathing and dressing). Most policies sold are in the individual market.

The cost of long-term care policies varies dramatically depending on a number of factors. The consumer's age at the time of purchase, the amount of coverage, and other policy features affect the policy's cost. Insurance companies can increase premiums for entire classes of individuals, such as all policyholders age 75 and older, based on their experience in paying benefits. Older adults are more likely to have more long-term care needs and higher costs, thus higher premiums. Other factors that affect the policy's premium include the duration of

benefits, the length of any waiting period before benefits are paid, the stringency of benefit triggers, whether policyholders can retain a partial benefit if they let their policy lapse for any reason, including inability to pay (nonforfeiture benefit), and whether the policy's benefits are adjusted for inflation. Individuals with federally qualified long-term care insurance policies can deduct their premiums from their taxes, up to a maximum limit, provided that the taxpayer itemizes deductions and has medical costs in excess of 7.5 percent of adjusted gross income.

There are several reasons why Americans have not purchased long-term care policies. Denial is an important factor – most of us do not want to think about needing long-term care assistance. About one-third of Medicare beneficiaries still believe that they can rely on Medicare for their long-term care. Cost is another critical factor. Younger individuals are often concerned with the immediate costs of monthly bills, as well as major items such as buying a home, putting children through college, and saving for retirement. People don't plan for long-term care needs that they don't know much about or think they will not have. People may also associate a long-term care insurance policy with institutionalization. Others may be leery of long-term care insurance due to large premium increases and market instability. In addition, some individuals are not able to qualify for long-term care insurance due to underwriting.

Consumer protections are an important part of long-term care insurance policies. Standards and protections for long-term care insurance policies could make them better products that consumers are more likely to buy. For example, an individual who buys a policy in his or her 60s may not need long-term care for over 20 years. Without inflation protection, the value of the insurance benefits can erode over time. A daily benefit of $100 in coverage will not buy as much care in 2025 as it does today. Nonforfeiture protection allows a consumer who has paid premiums for a policy, but can no longer afford to pay premiums to still receive some benefits from the policy.

The National Association of Insurance Commissioners (NAIC) has developed a Long-Term Care Insurance Model Act and Regulations that states can adopt to provide standards for long-term care insurance policies sold in a state. NAIC standards include: inflation protection, nonforfeiture, required disclosures to consumers, minimum standards for home health and community care benefits, premium rate stabilization, and standards for what triggers benefits. While all states have adopted some of the NAIC provisions, only 21 states have adopted a critical provision on premium stability that protects consumers from unreasonable rate increases that could make their policies unaffordable.

Legislation introduced in previous Congresses by Representatives Nancy Johnson (R-CT) and Earl Pomeroy (D-ND) includes consumer protections mandated by the Health Insurance Portability and Accountability Act of 1996 and

incorporates some of the consumer protections in the NAIC Model Act and Regulations. AARP supports the standards for long-term care insurance included in this legislation.

Long-Term Care Partnerships

A hybrid of the public/private approach to financing long-term care services is the Long-Term Care Partnership Program. Currently operating in four states (California, Connecticut, Indiana, and New York), the program allows individuals who buy long-term care insurance policies under the program to protect a certain amount of their assets and become eligible for Medicaid. People who purchase long-term care insurance policies under the Partnership are partially exempt from estate recovery under Medicaid, except for New York and Indiana which offer total asset protection. A provision in the Omnibus Budget Reconciliation Act of 1993 limited this estate recovery exemption to these four states who had state plan amendments approved by May 14, 1993 (plus Iowa which has not implemented a Partnership program).

The goals of the Partnership include encouraging people to buy private long-term care insurance when they might not otherwise do so; saving money for Medicaid by delaying or preventing spend-down to Medicaid eligibility; reducing the incentive for individuals to transfer assets; and saving money for individuals by

having them rely on insurance policies to cover long-term care costs that they would have paid otherwise.

According to recent evaluations of the program, about 181,600 insurance policies have been sold under the Partnership. About 149,300 are currently in force. Of the individuals who purchased policies, only about 2,200 persons (1.2 percent of Partnership purchasers) have used their long-term care insurance policies and only about 90 people have actually accessed Medicaid (0.5 percent of total purchasers). It is unclear whether these persons using Medicaid would have likely spent down to Medicaid absent their participation in the program. It is not clear whether the policies were purchased by people who otherwise would not have bought insurance, whether the Partnership policies are a substitute for other long-term care insurance policies, and whether participants would have used Medicaid regardless. Because Partnership policyholders tend to be younger than other long-term care policyholders, it may be hard to assess the full impact of the Partnership program on Medicaid. It is possible that not enough time has passed for many Partnership policyholders to have exhausted their long-term care insurance policy and become eligible for Medicaid.

The Partnership states use three different methods to determine the amount of assets that will be protected for program participants: a dollar-for-dollar model, a total assets model, and a hybrid model. California and Connecticut use the dollar-for-dollar model that protects $1 in assets for every $1 in benefits paid out

by the Partnership policy. New York uses a total assets approach where all of an individual's assets are protected if the individual purchases a Partnership policy with a minimum benefit package defined by the state and exhausts all of its benefits. New York is considering expanding its model to include a hybrid model. Indiana uses a hybrid model in which the amount of asset protection depends on the value of the benefits exhausted. To qualify for total asset protection, participants must exhaust a policy that covers about 4.2 years of nursing home care. Any policy with a benefit value below this amount would provide dollar-for-dollar protection. Partnership participants in California, Connecticut, and Indiana who have qualified for Medicaid have protected a total of $2.8 million in assets, according to recent studies.

According to a recent report by the Congressional Research Service on the program, the income and asset levels of Partnership program participants vary. Almost half of Partnership purchasers in California and Connecticut have assets of greater than $350,000 and 60 percent of purchasers in Indiana also have assets greater than this level (all excluding the home). An average of 20 percent of purchasers in California and Connecticut has assets of less than $100,000 (excluding the home). In New York, 13 percent have assets between $50,000 and $200,000. The dollar-for dollar-model allows states to approve more affordable options for lower-income consumers, while total asset protection encourages states to approve policies that are higher in value and more attractive to people with higher incomes. A significant number of participants in

California and Indiana, 58 percent and 43 percent respectively, have monthly incomes that exceed $5,000. Yet more than half of purchasers in Connecticut (57 percent) have income less than $2,500. In Indiana, 17 percent of purchasers had monthly income less than $3,000, 34.5 percent had monthly income between $3,000 and $5,000, and 43 percent had income of greater than $5,000.

Partnership programs may offer another option for financing long-term care but several improvements need to be made. These improvements include:

- Protecting the Medicaid safety net for low-income people who need long-term care. The Partnership may increase Medicaid long-term care expenditures if people with significant assets are able to access Medicaid more easily. If this occurs and states are unwilling or unable to spend more on Medicaid, additional beneficiaries could reduce the resources available to impoverished people who need care.

- Requiring stronger consumer protections, particularly nonforfeiture and inflation protection, premium stability, and clear disclosure of current income requirements for Medicaid benefits and the state's right to change those requirements. As discussed earlier, consumer protections are very important to long-term care policies. Partnership participants need to also be clear on the Medicaid income requirement and that it is a requirement

that they must meet for Medicaid eligibility after they have exhausted their long-term care policy.

- Guaranteeing the types of services (particularly home-and community-based services) that the state would provide to eligible Partnership policyholders under Medicaid. Most current Partnership policyholders will not need long-term care for many years. Without this protection they have no assurance that the services covered by Medicaid today will be covered in the future.

- Requiring that states monitor admissions to nursing homes to ensure that equal access is available to everyone on the waiting list, regardless of source of payments. Nursing homes should not be able to discriminate against residents based on who is paying for their care.

Conclusion

We can no longer afford to put the issue of long-term care financing on the back burner. Congress must begin to look for options that would allow Americans to pay for the care they need in the setting of their choice. We urge you to focus on the people behind the policy discussion of new financing options and budget implications – the faces of families struggling to help a grandparent with Alzheimer's or a parent with physical limitations, and the faces of older

Americans interested in staying independent and in their own homes for as long as possible.

AARP looks forward to working with this Committee, Congress, the Administration, and all stakeholders to address the broad long-term care needs our country is facing. We stand ready to work with members on both sides of the aisle to begin to tackle this important challenge.